Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

HEALTH AND MEDICAL PRACTICE ASSOC
324 NORTH 23RD STREET SUITE 201
BEAUMONT TX 77707

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box
Box Number 54

MFDR Tracking Number
M4-11-0509-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Claim was submitted under wrong Dr. Claim was corrected and denied as dup. Claim was appealed and denied as dup again. Please see attached system notes showing calls made to insurance co."

Amount in Dispute: $81.61

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

Response Submitted by: None

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 25, 2010	CPT Code 20550	$81.61	$80.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated April 22, 2010

- CAC-4-The procedure code is inconsistent with the modifier used or a required modifier is missing.
- CAC-45-Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use group code PR or CO depending upon liability).
- 732-Accurate coding is essential for reimbursement. CPT and/or modifier billed incorrectly. Services are not reimbursable as billed.
- 793-Reduction due to PPO contract. PPO contract was applied by Focus/Aetna Workers Comp Access LLC.

Explanation of benefits dated July 28, 2010

- CAC-18-Duplicate claim/service.
- 224-Duplicate charge.

Issues

1. Does a contractual agreement exist in this dispute.
2. Is the requestor entitled to reimbursement for CPT code 20550?

Findings

1. The respondent raised the issue of a contractual agreement on the Explanation of Benefits (EOBs) with reason codes "CAC-45-Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use group code PR or CO depending upon liability)"; and "793-Reduction due to PPO contract. PPO contract was applied by Focus/Aetna Workers Comp Access LLC ." The 'PPO Discount' amount on the submitted EOBs denotes a '$0.00" discount. The Division finds that documentation does not support that the services were discounted due to a contract; therefore, reimbursement for the services in dispute will be reviewed in accordance with applicable Division rules and fee guidelines.

2. Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
   (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.

   (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."

   The 2010 DWC Conversion factor is $54.32.

   Review of Box 32 on the CMS-1500 the services were rendered in zip code 78757, which is located in Travis County.

   CPT code 20550 is defined as "Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar "fascia")."

   The MAR for CPT code 20550 in Travis County is $80.00. The respondent paid $0.00; therefore,the requestor is due $80.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $80.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $80.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		5/31/2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.